FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013334

Facility Name: SACRED HEART HOME INC.

Address: 1550 S. ALBANY (Number) CHICAGO (City) 60623 (Zip Code)

County: COOK

Telephone Number: (773) 277-6868 **Fax #** (773) 277-5014

IDPA ID Number: 362707014001

Date of Initial License for Current Owners: 01/01/71

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) JEFFREY K. SINGER, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	172	Skilled (SNF)	172	62,780	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,780	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	55,004			55,004	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,004			55,004	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.61%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/1971

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	192,002	25,200	34,828	252,030		252,030		252,030			1
2	Food Purchase		322,033		322,033	(33,854)	288,179		288,179			2
3	Housekeeping	225,915	44,214	19,196	289,325		289,325		289,325			3
4	Laundry	11,787	20,317		32,104		32,104		32,104			4
5	Heat and Other Utilities			121,255	121,255		121,255	1,705	122,960			5
6	Maintenance	159,480		154,783	314,263		314,263	(37,550)	276,713			6
7	Other (specify):*											7
8	TOTAL General Services	589,184	411,764	330,062	1,331,010	(33,854)	1,297,156	(35,845)	1,261,311			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	437,678	23,714	418,661	880,053		880,053		880,053			10
10a	Therapy											10a
11	Activities	80,958	4,941	4,325	90,224		90,224	(353)	89,871			11
12	Social Services	117,865		35,684	153,549		153,549		153,549			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	636,501	28,655	458,670	1,123,826		1,123,826	(353)	1,123,473			16
	C. General Administration											
17	Administrative	226,876		573,000	799,876		799,876	(400,924)	398,952			17
18	Directors Fees											18
19	Professional Services			25,525	25,525		25,525	7,137	32,662			19
20	Dues, Fees, Subscriptions & Promotions			3,797	3,797		3,797	6,509	10,306			20
21	Clerical & General Office Expenses		12,778	56,843	69,621		69,621	110,879	180,500			21
22	Employee Benefits & Payroll Taxes			140,683	140,683	33,854	174,537	(1)	174,536			22
23	Inservice Training & Education											23
24	Travel and Seminar			120	120		120	110	230			24
25	Other Admin. Staff Transportation							3,073	3,073			25
26	Insurance-Prop.Liab.Malpractice			96,723	96,723		96,723	3,989	100,712			26
27	Other (specify):*							31,049	31,049			27
28	TOTAL General Administration	226,876	12,778	896,691	1,136,345	33,854	1,170,199	(238,179)	932,020			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,452,561	453,197	1,685,423	3,591,181		3,591,181	(274,377)	3,316,804			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SACRED HEART HOME INC. #0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			46,870	46,870		46,870	10,392	57,262			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,747	2,747		2,747	19,136	21,883			32
33	Real Estate Taxes							8,257	8,257			33
34	Rent-Facility & Grounds			188,400	188,400		188,400	(188,400)				34
35	Rent-Equipment & Vehicles			10,358	10,358		10,358		10,358			35
36	Other (specify):*											36
37	TOTAL Ownership			248,375	248,375		248,375	(150,615)	97,760			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		54,698		54,698		54,698	(42,912)	11,786			41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		54,698	94,170	148,868		148,868	(42,912)	105,956			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,452,561	507,895	2,027,968	3,988,424		3,988,424	(467,904)	3,520,520			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,212	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(35)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(359)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(606)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(96,783)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,571)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(374,333)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (374,333)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (467,904)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SACRED HEART HOME INC.

ID# 0013334

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	CAPITALIZED R&M	$ (44,850)	06	1
2	MISC EXPENSE	(123)	21	2
3	PPA - ACTIVITY CONSULTANT	(353)	11	3
4	PPA - PAYROLL	(1)	22	4
5	PPA - ADVERTISING AND PROMO	(120)	20	5
6	PENALTIES	(145)	21	6
7	VENDING	(42,912)	41	7
8	BLDG CO TAXES	(3,044)	21	8
9	NONCARE ASSET DEPRECIATION	(115)	30	9
10	BLDG CO PROFESSIONAL FEES	(5,120)	19	10
11				11
12				12
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,705									1,705	5
6	Maintenance	(44,850)		7,300									(37,550)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(44,850)		9,005									(35,845)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(353)											(353)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(353)											(353)	16
	C. General Administration													
17	Administrative			(573,000)	123,139	48,937							(400,924)	17
18	Directors Fees													18
19	Professional Services	(5,120)	5,120	7,137									7,137	19
20	Fees, Subscriptions & Promotions	(514)	120	6,903									6,509	20
21	Clerical & General Office Expenses	(3,918)	3,043	111,754									110,879	21
22	Employee Benefits & Payroll Taxes	(1)											(1)	22
23	Inservice Training & Education													23
24	Travel and Seminar			110									110	24
25	Other Admin. Staff Transportation			3,073									3,073	25
26	Insurance-Prop.Liab.Malpractice			3,989									3,989	26
27	Other (specify):*			18,761	8,009	4,279							31,049	27
28	**TOTAL General Administration**	(9,553)	8,283	(421,273)	131,148	53,216							(238,179)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,756)	8,283	(412,268)	131,148	53,216							(274,377)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	4,097		6,295									10,392	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			19,136									19,136	32
33	Real Estate Taxes		5,205	3,052									8,257	33
34	Rent-Facility & Grounds		(188,400)										(188,400)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	4,097	(183,195)	28,483									(150,615)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(42,912)											(42,912)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(42,912)											(42,912)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,571)	(174,912)	(383,785)	131,148	53,216							(467,904)	45

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	60.00%	SEE ATTACHED		SEE ATTACHED		
DANIEL O'BRIEN	20.00%					
MARY O'BRIEN	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 188,400	SACRED HEART BUILDING CO.		$	$ (188,400)	1
2	V	33	REAL ESTATE TAXES				5,205	5,205	2
3	V	20	LICENSES AND FEES				120	120	3
4	V	19	PROFESSIONAL FEES				5,120	5,120	4
5	V	21	TAXES				3,043	3,043	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 188,400			$ 13,488	$ * (174,912)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 1,705	$ 1,705	15
16	V	6	REPAIRS AND MAINT.				7,300	7,300	16
17	V	19	PROFESSIONAL FEES				7,137	7,137	17
18	V	20	DUES AND SUBSCRIPTIONS				6,903	6,903	18
19	V	21	CLERICAL AND GENERAL				111,754	111,754	19
20	V	24	SEMINARS				110	110	20
21	V	25	AUTO EXPENSE				3,073	3,073	21
22	V	26	PROPERTY INSURANCE				3,989	3,989	22
23	V	27	GEN. ADMIN. - EMP. BEN.				18,761	18,761	23
24	V	30	DEPRECIATION				6,295	6,295	24
25	V	32	INTEREST				19,136	19,136	25
26	V	33	REAL ESTATE TAXES				3,052	3,052	26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	573,000				(573,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 573,000			$ 189,215	$ * (383,785)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	$	MADO MGMT. LP	100.00%	$ 6,250	$ 6,250	15
16	V	27	EMP. BEN.-D. O'BRIEN				1,425	1,425	16
17	V								17
18	V	17	SALARY-P. O'BRIEN				96,667	96,667	18
19	V	27	EMP. BEN.-P. O'BRIEN				4,862	4,862	19
20	V								20
21	V	17	SALARY-C. STUMPF				20,222	20,222	21
22	V	27	EMP. BEN.-C. STUMPF				1,722	1,722	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 131,148	$ * 131,148	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$	$	15
16	V	6	REPAIRS AND MAINTENANCE						16
17	V	17	ADMINISTRATIVE SALARY				48,937	48,937	17
18	V	21	CLERICAL SALARY						18
19	V	27	GEN. ADMIN. - EMP. BEN.				4,279	4,279	19
20	V	30	DEPRECIATION-WAREHOUSE						20
21	V	33	REAL ESTATE TAXES						21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 53,216	$ * 53,216	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$ 30,528	WINDY CITY NURSING	100.00%	$ 30,528	$	15
16	V	10	NURSING	418,662	WINDY CITY NURSING	100.00%	418,662		16
17	V	11	ACTIVITY	1,294	WINDY CITY NURSING	100.00%	1,294		17
18	V	12	SOCIAL SERVICES	34,259	WINDY CITY NURSING	100.00%	34,259		18
19	V	21	OFFICE	59,531	WINDY CITY NURSING	100.00%	59,531		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 544,274			$ 544,274	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	DANIEL O'BRIEN	OWNER	Dir. Of Operation	20.00%	SEE ATTACHED	6	15.00%	Salary	$ 223,500	17-1	1
2	DANIEL O'BRIEN	OWNER	Dir. Of Operation	20.00%	SEE ATTACHED	6	15.00%	Alloc. Salary	6,250	17-7	2
3	PETER O'BRIEN	OWNER	Administrative	60.00%	SEE ATTACHED	16	26.67%	Alloc. Salary	96,667	17-7	3
4	CHARLES STUMPF	RELATIVE	Administrative		SEE ATTACHED	7	15.56%	Alloc. Salary	20,222	17-7	4
5	JAMES WEST	RELATIVE	Clerical		SEE ATTACHED	9.3	23.25%	Alloc. Salary	12,799	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 359,438		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	236,364	5	$ 7,328	$	55,004	$ 1,705	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	236,364	5	31,369		55,004	7,300	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	236,364	5	30,669		55,004	7,137	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	236,364	5	29,662		55,004	6,903	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	236,364	5	480,229	393,151	55,004	111,754	5
6	24	SEMINARS	PATIENT DAYS	236,364	5	473		55,004	110	6
7	25	AUTO EXPENSE	PATIENT DAYS	236,364	5	13,206		55,004	3,073	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	236,364	5	17,140		55,004	3,989	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	236,364	5	80,619		55,004	18,761	9
10	30	DEPRECIATION	PATIENT DAYS	236,364	5	27,053		55,004	6,295	10
11	32	INTEREST	PATIENT DAYS	236,364	5	82,230		55,004	19,136	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	236,364	5	13,113		55,004	3,052	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 813,091	$ 393,151		$ 189,215	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	25,000	25,000	6	6,250	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	5,698		6	1,425	2
3										3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	271,875	271,875	16	96,667	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	13,673		16	4,862	5
6										6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	130,000	130,000	7	20,222	7
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	11,070		7	1,722	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 457,316	$ 426,875		$ 131,148	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	2,669				1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1	20				2
3	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	311,812	311,812		48,937	3
4	21	CLERICAL SALARY	DIRECT ALLOCATION		2	89,754	89,754			4
5	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	50,832			4,279	5
6	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1	1,082				6
7	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	1,810				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 457,979	$ 401,566		$ 53,216	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Windy City Nursing
Street Address: 1541 N. Wells
City / State / Zip Code: Chicago, IL 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	DIRECT ALLOC.			$	$		$ 30,528	1
2	10	NURSING	DIRECT ALLOC.						418,662	2
3	11	ACTIVITY	DIRECT ALLOC.						1,294	3
4	12	SOCIAL SERVICES	DIRECT ALLOC.						34,259	4
5	21	OFFICE	DIRECT ALLOC.						59,531	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 544,274	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	TIFCO		X	INSURANCE FINANCING							2,747	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 2,747	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11												11
12	Allocation-MADO Mgmt	X									19,136	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 19,136	14
15	TOTALS (line 9+line14)						$	$			$ 21,883	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 1,150	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 6,153	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,003	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 3,256	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 8,259	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	728	8
	1997	696	9
	1998	1,082	10
	1999	1,075	11
	2000	3,101	12

LINE 2 INCLUDES $3052 ALLOCATION FROM MADO; AND $3101 FROM SACRED HEART BUILDING COMPANY

REAL ESTATE TAX ACCRUAL = 2000 TAX X 1.05

$3101 X 1.05 = $3256

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SACRED HEART HOME INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0013334

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-24-106-035	Long Term Care	$ 398.43	$ 398.43
2.	16-24-106-036	Long Term Care	$ 780.98	$ 780.98
3.	16-24-106-037	Long Term Care	$ 1,921.30	$ 1,921.30
4.	17-04-201-012	Allocated - Related Party	$ 19,284.33	$ 3,052.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,385.04	$ 6,152.71

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,940 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 22,077	1
2					2
3	TOTALS			$ 22,077	3

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	172		1971	1971	$ 140,000	$	35	$	$	$ 140,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1973	9,000		20	-		9,000	9
10	Various			1975	16,880		20	-		16,880	10
11	Various			1976	4,234		20	-		4,234	11
12	Various			1977	43,234		20	-		43,234	12
13	Various			1978	50,867		20	-		50,867	13
14	Various			1979	40,393		20	-		40,393	14
15	Various			1980	4,392		20	-		4,392	15
16	Various			1981	15,817		20	-		15,817	16
17	Various			1982	15,180		20	-		15,180	17
18	Various			1984	7,505		20	-		7,505	18
19	Various			1985	60,377		20	-		60,377	19
20	Various			1986	41,792		20	-		41,792	20
21	Various			1987	17,344		20	1,156	1,156	17,343	21
22	Various			1988	13,840		20	-		13,824	22
23	Various			1989	10,568		20	-		10,568	23
24	Various			1990	48,324		20	1,444	1,444	43,990	24
25	Various			1991	26,113		20	132	132	24,731	25
26	Various			1992	105,671		20	5,284	5,284	78,227	26
27	Various			1993	14,487		20	724	724	12,372	27
28	Various			1994	37,950		20	1,898	1,898	15,184	28
29	Various			1995	38,705		20	1,935	1,935	11,610	29
30	Various			1996	34,431		20	1,721	1,721	10,658	30
31	Various			1997	62,792		20	2,993	2,993	13,844	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		71,665	2,466		2,533	67	16,624	68
69	Financial Statement Depreciation			27,108			(27,108)		69
70	TOTAL (lines 4 thru 69)		$ 931,561	$ 29,574		$ 19,820	$ (9,754)	$ 718,646	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 931,561	$ 29,574		$ 19,820	$ (9,754)	$ 718,646	1
2	CRAFTY-CEILING TILES	1998	1,599		20	80	80	267	2
3	HOLLUB-A/C REPAIR	1998	973		20	49	49	163	3
4	HOLLUB-BURNER REPAIR	1998	2,345		20	117	117	371	4
5	VERTIDRAPES-BLINDS	1998	1,435		20	72	72	240	5
6	J & L - DOORS	1998	4,994		20	250	250	958	6
7	J & L - METAL DOORS	1998	1,268		20	63	63	252	7
8	VERTIDRAPES-BLINDS	1998	3,600		20	180	180	705	8
9	KOLD MASTERS-THERMOS	1998	2,225		20	111	111	435	9
10	J & L - METAL DOORS	1998	1,865		20	93	93	349	10
11	ALL ELEVATOR-RECLAIM	1998	5,000		20	250	250	979	11
12	JOHN HARRIS-ROOF	1998	2,800		20	140	140	525	12
13	JOHN HARRIS-ROOF REP	1998	5,500		20	275	275	1,031	13
14	JOHN HARRIS-ROOF REP	1998	1,000		20	50	50	179	14
15	JOHN HARRIS-TUCKPOIN	1998	3,000		20	150	150	475	15
16	KELCO-A/C REPAIR	1998	1,060		20	53	53	212	16
17	KELCO-FIRE ALARM REP	1998	1,613		20	81	81	324	17
18	KELCO-LIGHTING REPAI	1998	1,120		20	56	56	219	18
19	F&D HOME IMP-GATE RE	1998	1,025		20	51	51	191	19
20	KELCO-RELOCATE SPRIN	1998	790		20	40	40	150	20
21	KELCO-LIGHTING REAR	1998	993		20	50	50	188	21
22	ATASH-SPRINKLER WORK	1998	1,258		20	63	63	231	22
23	RUSH-FIRE DAMPERS	1998	2,547		20	127	127	445	23
24	HOLLUB-A/C REPAIR	1998	591		20	30	30	110	24
25	JOHN HARRIS-ROOF REP	1998	1,000		20	50	50	175	25
26	JOHN HARRIS-ROOF REP	1998	1,000		20	50	50	183	26
27	JOHN HARRIS-ROOF REP	1998	900		20	45	45	165	27
28	HOLLEB-BOILER	1998	17,935		20	897	897	3,588	28
29	NAT.AWNING-FRONT AWN	1998	750		20	38	38	136	29
30	F & D -SECURITY BAR	1998	1,000		20	50	50	154	30
31	DOOR	1998	675		20	34	34	136	31
32	ELEVATOR DOOR	1998	700		20	35	35	128	32
33	DOORS	1998	675		20	34	34	91	33
34	TOTAL (lines 1 thru 33)		$ 1,004,797	$ 29,574		$ 23,484	$ (6,090)	$ 732,401	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,004,797	$ 29,574		$ 23,484	$ (6,090)	$ 732,401	1
2	4 CABINETS	1999	788		20	39	39	98	2
3	VERTICAL BLINDS	1999	1,121		20	56	56	163	3
4	DOOR	1999	2,845		20	142	142	426	4
5	DOORS	1999	660		20	33	33	88	5
6	10 MINI BLINDS	1999	620		20	31	31	93	6
7	CARPET	1999	1,541		20	77	77	193	7
8	ROOFTOP A/C UNIT	1999	2,465		20	123	123	308	8
9	ROOFTOP A/C UNIT	1999	739		20	37	37	93	9
10	2 DOORS	1999	1,814		20	91	91	212	10
11	2 DOORS	1999	1,736		20	87	87	203	11
12	4 VERTICAL BLINDS	1999	1,098		20	55	55	119	12
13	DOOR	1999	1,025		20	51	51	106	13
14	GUTTER REPAIR	1999	1,250		20	63	63	189	14
15	ELECTRICAL WORK	1999			20				15
16	ELECTRICAL WORK	1999			20				16
17	ROOF REPAIR	1999			20				17
18	CAPACITOR-ROOFTOP AC	1999	580		20	29	29	70	18
19	ROOF REPAIR	1999	3,607		20	180	180	420	19
20	ROOF REPAIR	1999	3,300		20	165	165	385	20
21	ELEVATOR HYD.PUMP	1999	2,145		20	107	107	250	21
22	ROOF REPAIR	1999	2,625		20	131	131	306	22
23	PLATED STEEL-ELEVATO	1999	2,110		20	106	106	230	23
24	WELDING-FEED TANK	1999	1,635		20	82	82	178	24
25	PAINT	1999	1,044		20	52	52	113	25
26	HARDWARE SUPPLIES-UP	1999	2,622		20	131	131	273	26
27	2ND FLR SECURITY CAM	1999	1,378		20	69	69	219	27
28	ELECTRIC LOCK SYSTEM	1999	1,950		20	98	98	294	28
29	EMERG.PANEL-GENERATO	1999	4,535		20	227	227	605	29
30	CLOSED CIRCUIT SEL	1999	2,688		20	134	134	335	30
31	3RD FLOOR PLUMBING	1999	729		20	36	36	72	31
32	3RD FLOOR PLUMBING	1999	720		20	36	36	72	32
33	PIPING & VALVES	1999	609		20	30	30	60	33
34	TOTAL (lines 1 thru 33)		$ 1,054,776	$ 29,574		$ 25,982	$ (3,592)	$ 738,574	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,054,776	$ 29,574		$ 25,982	$ (3,592)	$ 738,574	1
2	HEATING/COOLING	1999	1,293		20	100	100	200	2
3	SPRINKLER HEADS	2000	1,341		20	67	67	134	3
4	SPRINKLER HEADS	2000	501		20	25	25	50	4
5	SMOKE DETECTORS/CCTV	2000	705		20	35	35	67	5
6	GLASS & CLEAR WIRE	2000	505		20	25	25	48	6
7	DOOR	2000	701		20	35	35	44	7
8	WALL GUARD	2000	1,853		20	93	93	186	8
9	FAN FOR HEATER	2000	750		20	38	38	41	9
10	DOORS	2000	544		20	27	27	47	10
11	WIRE GLASS	2000	650		20	33	33	52	11
12	ELECTRICAL	2000	1,450		20	73	73	128	12
13	PAINT	2000	764		20	38	38	60	13
14	PAINT	2000	914		20	46	46	73	14
15	BLINDS	2000	3,356		20	168	168	280	15
16	BASEMENT DOORS	2000	1,223		20	61	61	102	16
17	DOORS & HINGES	2000	501		20	25	25	46	17
18	IRON ON STEPS	2000	1,365		20	68	68	113	18
19	STEPS DEMOLITION	2000	895		20	45	45	71	19
20	CONCRETE	2000	3,750		20	189	189	299	20
21	REPLACE BRICKS	2000	6,000		20	300	300	550	21
22	ROOFING	2000	2,500		20	125	125	219	22
23	ROOFING	2000	2,500		20	125	125	219	23
24	ROOFING	2000	5,250		20	263	263	395	24
25	WIRING	2000	1,000		20	50	50	88	25
26	ALARM PANEL	2000	3,800		20	190	190	333	26
27	ALARM SYSTEM	2000	6,500		20	325	325	515	27
28	COMPRESSOR	2000	2,125		20	106	106	194	28
29	CARPET	2000	1,021		20	51	51	98	29
30	SPRINKLER	2000	544		20	27	27	45	30
31	SPRINKLER	2000	1,551		20	78	78	124	31
32	SPRINKLER	2000	875		20	44	44	66	32
33	GENERATOR	2000	1,832		20	92	92	169	33
34	TOTAL (lines 1 thru 33)		$ 1,113,335	$ 29,574		$ 28,949	$ (625)	$ 743,630	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,113,335	$ 29,574		$ 28,949	$ (625)	$ 743,630	1
2	ELECTRICAL	2000	1,129		20	56	56	112	2
3	DOORS	2000	2,553		20	128	128	256	3
4	DOORS	2000	4,694		20	235	235	372	4
5	DOOR SWEEP	2000	698		20	35	35	53	5
6	DOOR SWEEP	2000	3,408		20	170	170	227	6
7	DOOR SWEEP	2000	701		20	35	35	44	7
8	HOT WATER LINE	2000	1,135		20	57	57	109	8
9	SUMP PUMP	2000	2,236		20	112	112	205	9
10	CAFETERIA A/C	2000	5,030		20	252	252	378	10
11	PLASTER BOARD	2000	3,247		20	162	162	324	11
12	WOOD RAILING	2000	4,293		20	215	215	412	12
13	PLASTER BOARD	2000	1,501		20	75	75	125	13
14	DOORS	2000	1,125		20	56	56	107	14
15	STEPS	2000	17,150		20	858	858	1,287	15
16	STEPS	2000	6,460		20	323	323	485	16
17	ELEVATOR REPAIR	2000	7,860		20	33	33	33	17
18	AIR CONDITIONERS *	2001	5,208		20	130	130	130	18
19	VERTICAL BLINDS *	2001	1,778		20	82	82	82	19
20	AIR CONDITIONERS *	2001	10,403		20	217	217	217	20
21	PIPES AND FITTINGS	2001	1,089		20	54	54	54	21
22	CHAINLINK FENCING	2001	1,041		20	52	52	52	22
23	120V COIL	2001	818		20	38	38	38	23
24	RADIATOR CABINET	2001	4,052		20	186	186	186	24
25	HANDRAILS	2001	2,400		20	100	100	100	25
26	HOT WATER LINE	2001	1,460		20	61	61	61	26
27	METAL DOOR	2001	1,327		20	55	55	55	27
28	STEEL PIPE COLUMNS	2001	4,850		20	182	182	182	28
29	FLOOR TILES	2001	10,151		20	423	423	423	29
30	FLOOR TILES	2001	5,890		20	221	221	221	30
31	SECURITY MONITOR	2001	732		20	28	28	28	31
32	SECURITY CAMERA	2001	1,239		20	47	47	47	32
33	SECURITY MONITOR CAMERAS	2001	1,073		20	36	36	36	33
34	TOTAL (lines 1 thru 33)		$ 1,230,066	$ 29,574		$ 33,663	$ 4,089	$ 750,071	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,230,066	$ 29,574		$ 33,663	$ 4,089	$ 750,071	1
2	INSTALLED HEATER	2001	670		20	23	23	23	2
3	TUBS	2001	2,256		20	75	75	75	3
4	WATER LINES	2001	11,072		20	416	416	416	4
5	VERTICAL BLINDS	2001	1,778		20	82	82	82	5
6	HANDRAILS	2001	600		20	18	18	18	6
7	FENCE *	2001	13,132		20	164	164	164	7
8	ROOF *	2001	27,150		20	226	226	226	8
9	FENCE *	2001	1,475		20	6	6	6	9
10	HANDRAIL BARS *	2001	4,500		20	19	19	19	10
11	ELEVATOR REPAIR *	2001	4,324		20	216	216	216	11
12	PAINT *	2001	673		20	34	34	34	12
13	PAINT *	2001	631		20	24	24	24	13
14	BOILER REPAIR *	2001	765		20	19	19	19	14
15	PLUMBING *	2001	854		20	22	22	22	15
16	FENC*	2001	7,340		20	122	122	122	16
17	WIRING *	2001	1,777		20	30	30	30	17
18	LANDSCAPE ROCKS *	2001	500		20	8	8	8	18
19	FENCE *	2001	2,142		20	27	27	27	19
20	ELEVATOR REPAIR *	2001	726		20	21	21	21	20
21	WATER LINES *	2001	2,744		20	34	34	34	21
22	ROOFING MATERIALS *	2001	698		20	6	6	6	22
23	SINK *	2001	627		20	5	5	5	23
24	COMPRESSOR *	2001	1,750		20	37	37	37	24
25	ACCESS LADDERS *	2001	3,750		20	31	31	31	25
26	FENCE *	2001	1,722		20	14	14	14	26
27	FIXED LADDER GUARD *	2001	870		20	4	4	4	27
28	FENCE *	2001	2,645		20	11	11	11	28
29	ROOF WORK *	2001	975		20	4	4	4	29
30	FENCE *	2001	3,235		20	14	14	14	30
31	PAINT *	2001	3,033		20	13	13	13	31
32	FIRE ESCAPE PAINTING *	2001	1,795		20	8	8	8	32
33	* Assets added after 7/1/01	2001			20				33
34	TOTAL (lines 1 thru 33)		$ 1,336,275	$ 29,574		$ 35,396	$ 5,822	$ 751,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,336,275	$ 29,574		$ 35,396	$ 5,822	$ 751,804	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,336,275	$ 29,574		$ 35,396	$ 5,822	$ 751,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,336,275	$ 29,574		$ 35,396	$ 5,822	$ 751,804	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,336,275	$ 29,574		$ 35,396	$ 5,822	$ 751,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,336,275	$ 29,574		$ 35,396	$ 5,822	$ 751,804	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,336,275	$ 29,574		$ 35,396	$ 5,822	$ 751,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988		$ 48,235	$ 1,754	35	$ 1,378	$ (376)	$ 8,269	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOC-MADO MGMT			1993	18,373	489	35	919	430	7,739	9
10	ALLOC-MADO MGMT			1995	1,119	223	35	56	(167)	364	10
11	ALLOC-MADO MGMT			2000	2,748	-	35	137	137	209	11
12	ALLOC-MADO MGMT			2001	1,190	-	35	43	(43)	43	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 71,665	$ 2,466		$ 2,533	$ (19)	$ 16,624	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 197,272	$ 21,701	$ 16,242	$ (5,459)	10	$ 119,536	71
72	Current Year Purchases	10,261		733	733	10	733	72
73	Fully Depreciated Assets	80,810				10	80,810	73
74								74
75	TOTALS	$ 288,343	$ 21,701	$ 16,975	$ (4,726)		$ 201,079	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1997 JEEP GRAND CHER	1998	$ 24,457	$ 1,775	$ 4,891	$ 3,116	5	$ 15,488	76
77										77
78										78
79										79
80	TOTALS			$ 24,457	$ 1,775	$ 4,891	$ 3,116		$ 15,488	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,671,151	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,050	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,262	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,212	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 968,371	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BOILER REPAIR - 1997	$ 2,297	$ 115	$ 575	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 2,297	$ 115	$ 575	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 10,358 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 253	$ 253	1
2	Cash-Patient Deposits	29,589	29,589	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,282,887	1,282,887	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,012	33,012	6
7	Other Prepaid Expenses	190	190	7
8	Accounts Receivable (owners or related parties)	3,641,657	4,971,373	8
9	Other(specify): See supplemental schedule	5,987	5,987	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,993,575	$ 6,323,291	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		22,077	13
14	Buildings, at Historical Cost		140,000	14
15	Leasehold Improvements, at Historical Cost	1,048,110	1,048,110	15
16	Equipment, at Historical Cost	293,980	308,980	16
17	Accumulated Depreciation (book methods)	(783,185)	(938,185)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 558,905	$ 580,982	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,552,480	$ 6,904,273	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,121,813	$ 1,169,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,426	4,426	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,334	44,334	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		3,256	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,170,573	$ 1,221,101	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,170,573	$ 1,221,101	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,381,907	$ 5,683,172	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,552,480	$ 6,904,273	48

*(See instructions.)

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,315,042	1
2	Restatements (describe):		2
3			3
4	INCOME RESTATEMENT	(167,261)	4
5	EXPENSE RESTATEMENT	(39,015)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,108,766	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,273,141	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,273,141	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,381,907	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,218,653	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,218,653	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	42,912	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 42,912	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,261,565	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,331,010	31
32	Health Care	1,123,826	32
33	General Administration	1,136,345	33
	B. Capital Expense		
34	Ownership	248,375	34
	C. Ancillary Expense		
35	Special Cost Centers	54,698	35
36	Provider Participation Fee	94,170	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,988,424	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,273,141	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,273,141	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,493	3,549	57,005	16.06	3
4	Licensed Practical Nurses	4,354	4,809	64,949	13.51	4
5	Nurse Aides & Orderlies	38,380	42,746	315,724	7.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,579	14,702	80,958	5.51	10
11	Social Service Workers	15,377	16,319	117,865	7.22	11
12	Dietician	4,635	5,242	35,417	6.76	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,410	22,732	156,449	6.88	15
16	Dishwashers	24	24	136	5.67	16
17	Maintenance Workers	20,900	22,800	159,480	6.99	17
18	Housekeepers	34,045	36,429	225,915	6.20	18
19	Laundry	1,916	2,102	11,787	5.61	19
20	Administrator					20
21	Assistant Administrator	308	308	3,376	10.96	21
22	Other Administrative	312	312	223,500	716.35	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,733	172,074	$ 1,452,561 *	$ 8.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	172	$ 4,300	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	4,325	11-03	44
45	Social Service Consultant	27	1,425	12-03	45
46	Other(specify)				46
47	OUTSIDE LABOR-DIETARY	2,424	30,528	01-03	47
48	OUTSIDE LABOR - SOC. SERV	2,546	34,259	12-03	48
49	TOTAL (lines 35 - 48)	5,220	$ 74,837		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	12,460	$ 289,942	10-03	50
51	Licensed Practical Nurses	4,899	128,719	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	17,359	$ 418,661		53

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel O'Brien	Dir. Of Operations	20%	$ 223,500
Isabel Aguilar	Asst. Admin	0	3,377
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 226,877

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 573,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 573,000

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 11,197
Wolf & Company	Accounting	4,261
Maemar, PC	Architects	875
McTigue & Spiewak	Surveyors	3,500
Personnel Planners	Unemployment Consultant	828
Health Data Systems	Data Processing	4,864
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 25,525

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,680
Unemployment Compensation Insurance	8,866
FICA Taxes	111,121
Employee Health Insurance	
Employee Meals	33,854
Illinois Municipal Retirement Fund (IMRF)*	
401K	15
TOTAL (agree to Schedule V, line 22, col.8)	$ 174,536

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,000
Advertising: Employee Recruitment	1,381
Health Care Worker Background Check	108
(Indicate # of checks performed 10)	
ALLOC-MADO MANAGEMENT	6,903
LICESENSE, DUES AND FEES	793
ADVERTISING AND PROMO	479
ALLOC-BLDG CO	120
Less: Public Relations Expense	
Non-allowable advertising	(479)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,305

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	120
ALLLOC-MADO MANAGEMENT	110
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 230

**See instructions.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **350** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **94,170**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **33,854** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees